

Sexual Orientation, Treatment Preferences, and Appeal of LGB Affirmative Therapy

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This thesis titled
Sexual Orientation, Treatment Preferences, and Appeal of LGB Affirmative Therapy

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ABSTRACT

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This study 1) examined whether preferences for traditional psychotherapy treatments (i.e. cognitive behavior therapy [CBT], humanistic therapy [HT], psychodynamic therapy [PDT]) differed by sexual orientation (SO) and 2) investigated the appeal of Lesbian, Gay, Bisexual Affirmative Therapy (LGB-AT) for LGB individuals. Participants were 174 undergraduates from a large Midwestern university and Amazon Mechanical Turk survey-takers. Participants ranked their preferences for the traditional therapies after reading approximately 500-word therapy descriptions with parallel structures including: theory of psychological problems, goals, methods, and client/therapist roles. Heterosexual participants preferred both HT and CBT to PDT, whereas LGB participants most preferred HT. LGB participants completed a second ranking which included LGB-AT *and* the traditional treatments. Contrary to predictions, LGB participants did not prefer LGB-AT to any of the traditional treatments. The authors theorized that LGB-AT may homogenize sexual minorities' experiences, rather than focusing on each individual's unique experience. Practical implications and future directions are discussed.

DEDICATION

*I dedicate this thesis to my parents, Jeff and Mary Jane McCarrick, who have
continuously supported my education.*

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CHAPTER 1: INTRODUCTION

In the past few decades, society and mental health institutions have made vast strides in their perceptions and treatment of lesbian, gay, and bisexual (LGB) individuals (Keleher & Smith, 2012). However, despite the fact that LGB individuals seek mental health treatment to a greater extent than the general population (Cochran & Mays, 2000; Cochran, Sullivan, & Mays, 2003; Liddle, 1997), there remains a dearth of empirical attention toward psychological treatment of LGB individuals. Because sexual minorities often experience oppression and isolation in addition to the problems heterosexual individuals experience, they may have a greater need for therapy as well as specific therapeutic considerations (Bennett & Douglass, 2013; Israel, Walther, Gortcheva, & Perry, 2011; Murphy, Rawlings, & Howe, 2002). Despite these unique adversities, relatively few treatments specifically oriented to the needs and preferences of these clients have been developed (Israel et al., 2011). Therefore, there may be a discrepancy between LGB clients' needs for mental health services and the availability of services specifically designed to meet their needs and preferences.

One promising methodological approach for exploring how best to meet LGB clients' mental health treatment needs is to investigate which types of common psychotherapy treatments LGB individuals prefer, to examine the appeal of a therapy created specifically for this group, and to determine the extent to which these preferences are predicted by relevant individual characteristics. Accordingly, the current study examined: 1) sexual orientation (SO) differences in preferences for traditional treatments, 2) LGB individuals' preferences for LGB-Affirmative Therapy (LGB-AT) as compared

to traditional treatments, and 3) whether treatment-relevant individual characteristics predicted treatment preferences.

Preferences

Health care providers have become increasingly focused on patient choices and preferences for treatment (Barry & Edgman-Levitan, 2012; Hibbard, 2003). According to the American Psychological Association, addressing mental health clients' preferences is crucial to providing evidence-based mental health care (APA, 2006). Moreover, when clients receive the type of treatment they prefer, their expectations for the treatment's success are higher, and they tend to experience better outcomes (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011; Swift & Callahan, 2009). However, it can be difficult to accommodate client preferences in mental health interventions because therapists are often unaware of clients' preferences or expressed preferences are not part of therapists' typical practice (Swift, Callahan, & Vollmer, 2011). Thus, clinical practice may benefit from increased awareness of clients' preferences.

A client's willingness to engage in therapy is often conceptualized in terms of expectations, which are *beliefs* about what treatment or treatment outcome will be like. Distinct from expectations, client preferences are defined as "the variables that clients show a desire for in the therapy encounter" (Swift, Callahan, Ivanovic, & Kominiak, 2013, p. 134). Preferences can include desirability of roles, type of treatment, or type of therapist (Glass, Arnkoff, & Shapiro, 2001). The present study focused specifically on *treatment* preferences, i.e. preferential attitudes between modalities of treatment or for features within a treatment (Berg, Sandahl, & Clinton, 2008).

A provider's adherence to treatment preferences is associated with positive process experiences (e.g. increased client engagement in therapy, see Elkin et al., 1999) and successful outcomes including: reduced depression (Kocsis et al., 2009), reduced anxiety (Berg et al., 2008), reduced substance abuse (Brown, Seraganian, Tremblay, & Annis, 2002), and reduced specific phobia symptoms (Devine & Fernald, 1973), among others. Meta-analyses of preference research have demonstrated that, across studies, adherence to preferences predicts lower dropout rates and better outcomes (Swift & Callahan, 2009; Swift et al., 2011; Swift et al., 2013). The effect of adherence to preferences on outcome underscores the importance of the therapist's knowledge of whether and for whom preferences diverge; when therapists are trained to meet the needs and preferences of a broad range of clients, they are better equipped to provide a preferred therapy that may lead to a better outcome (Inman, 2006).

In this regard, understanding preferences may be especially important for cultural minority clients. Notably, minority groups have low rates of engagement in therapy (González et al., 2010), which may be due in part to a perception that accepted traditional treatments may not always fit with clients from diverse backgrounds (Smith, Rodriguez, & Bernal, 2011). A perception that culturally-sensitive preferences will be known and accommodated in treatment may increase help-seeking and engagement in therapy among cultural minorities. Some prior research has explored preferences among diverse clients, with mixed findings suggesting differences in preferences between genders, race/ethnicities, and other cultural groups (e.g. Cooper et al., 2003; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Jimenez, Bartels, Cardenas, Dhaliwal, & Alegría, 2012; Rokke, Carter, Rehm, & Veltum, 1990).

Traditional Treatments

The present study explored cultural differences in preferences specifically for three “traditional” treatments: cognitive behavioral therapy (CBT), psychodynamic therapy (PDT), and humanistic therapy (HT). These therapies were chosen because each derives from one of the three most common theoretical orientations held by practitioners (Levy & Anderson, 2013). CBT takes a directive approach which emphasizes future experiences and maladaptive and irrational thoughts, involves assigning activities outside of session, and provides psychoeducation about the intervention, presenting psychological disorders, and symptomology (Hilsenroth, 2007). In comparison, PDT emphasizes past experiences, emotion expression, the therapeutic relationship, and the client’s desires and fantasies and investigates avoided topics and experiences (Hilsenroth, 2007). Finally, HT is more nondirective with an emphasis on the client in the present moment in session. HT is based on the idea that psychological distress emerges when human psychological growth is blocked, rendering the individual less able to self-explore through experience. In HT, it is assumed that when clients are encouraged to make their own decisions, they will naturally gravitate towards pathways of growth and satisfaction (Elliott, 1996).

Some prior research has examined preferences for treatments from various theoretical orientations. Generally, cognitive behavioral therapy and related treatments seem to be preferred to psychodynamic psychotherapy (e.g. Becker, Darius, & Schaumberg, 2007; Bragesjö, Clinton, & Sandell, 2004; Johansson, Nyblom, Carlbring, Cuijpers, & Andersson, 2013; Tarrier, Liversidge, & Gregg, 2006; Wanigaratne & Barker, 1995) and to humanistic therapy (e.g. Stuehm, Cashen, & Johnson, 1977;

Wanigaratne & Barker, 1995). It should be noted that, in some of these studies, treatments were designated for symptom reduction for particular disorders [e.g. PTSD, depression] which may have swayed preferences toward CBT. Furthermore, few recent preference studies have included humanistic therapy as a possible choice.

Despite an apparent overall preference for CBT, there is some evidence that preferences for treatments stemming from the common theoretical orientations vary according to an individual's cultural background. For example, Yu (1998) reported that White individuals endorsed stronger preferences for CBT than process-experiential (which is related to HT) and short-term dynamic (which falls under PDT) therapy. However, Asian immigrants and first-generation Asian Americans, as opposed to non-first generation Asian Americans, rated process-experiential therapy higher than the other two therapies. Additionally, all three types of therapy reportedly appealed more so to women than to men (Yu, 1998). When CBT and PDT were compared in another study by Chacon (2009), both Mexican-American and White individuals preferred CBT over PDT. However, this preference was stronger for White individuals (Chacon, 2009). These studies provide useful information about gender and ethnic differences in treatment preferences, but leave the relationship between treatment preferences and many other facets of diversity unexplored. For instance, to our knowledge, no studies have been conducted to date examining variability in preferences for common traditional treatments (i.e. CBT, HT, PDT) according to sexual orientation.

LGB Individuals' Preferences

Given the evidence that preferences for treatment type can differ between sexes and racial and ethnic groups, it is conceivable that such differences would also emerge

between individuals of different SOs. The small body of research that has explored LGB individuals' preferences focuses almost exclusively on therapist and role preferences (e.g. McDermott, Tyndall, & Lichtenberg, 1989; Burckell and Goldfried, 2006; Jones, Botsko, and Gorman, 2003; Liddle, 1997), rather than on treatment preferences. Only one known study examined LGB individuals' preferences for treatment modality, though between-group differences in preferences for outpatient therapy, inpatient therapy, self-help groups, literature, and computer-based interventions for alcohol use were not detected (Green, 2011). Thus, research in LGB individuals' treatment preferences is limited.

As with other cultural minorities, there are specific cultural considerations for psychotherapy with sexual minorities. Compared to heterosexual individuals, LGB individuals may perceive more barriers to help-seeking such as belief that their problems will be minimized, that they will be stigmatized, or that therapy will be a negative experience (Green, 2011). Indeed, the unique treatment needs and preferences of sexual minorities may be obfuscated by mistrust of mental health care professionals resulting from past psychotherapy practices (e.g. SO conversion therapies) which pathologized same-sex attraction (Langdridge, 2007; Eubanks-Carter, Burckell, & Goldfried, 2006). Notably, both behavioral and psychodynamic orientations, but not humanistic, have histories of including SO conversion therapies (Murphy, 1992). It is plausible then that HT carries less stigma from a heterosexist history than either CBT or PDT, and thus may appeal more to LGB clients.

Furthermore, there is some evidence to suggest that internalized homonegativity (i.e. negative attitudes that LGB individuals may hold towards themselves or their sexual orientation) as well as apprehension about feeling rejected may inhibit LGB clients from

sharing life experiences in therapy (Kus, 1992). Because of this, it is possible that LGB individuals would be less likely to choose a therapy like PDT in which there is a focus on exploration of past experiences (Hilsenroth, 2007) than to choose a therapy like HT in which topics of discussion are largely directed by the client (Cain, 2002).

Additionally, treatments that adhere to the Principles of Empirically Supported Interventions (Wampold, Lichtenberg, & Waehler, 2002) do not always account for how minority status and cultural context affect how clients perceive and succeed in treatment (Chambless et al., 1996; Hall, 2001; Lau, 2006; Quintana & Atkinson, 2002). In other words, more ‘standardized’ or ‘manualized’ types of treatments may be perceived as lacking in consideration for the differential experience of minority groups like sexual minorities (e.g. Hall, 1994). LGB individuals may be less likely to seek treatment if they perceive available treatments as potentially discriminatory or unconcerned with their individual experiences as sexual minorities (Dillworth, Kaysen, Montoya, & Larimer, 2009). For this reason, it is possible that a less standardized, more non-directive treatment like HT may be preferred by this group. However, basic science studies are needed to provide support for these conjectures, a primary goal of the present study.

Treatments may also have disparate appeal depending on certain individual characteristics. If LGB individuals tend to prefer HT because it is open and explorative, non-directive, and accepting, characterological openness to experience might drive LGB individuals’ preferences for HT as opposed to CBT or PDT. Furthermore, LGB people who feel that they have low social support as opposed to those with high social support may be more likely to prefer an accepting, non-judgmental treatment like HT. Thus,

openness to experience and perceived social support may predict, or even underscore, preferences for humanistic therapy as opposed to the other traditional treatments.

LGB Affirmative Therapy

Given a choice between the three aforementioned traditional treatments, LGB individuals may be most likely to prefer humanistic therapy. However, it could be that a treatment specifically designed for LGB clients may be even more preferable to LGB individuals. Therefore, a second aim of the current study was to determine the preferences of LGB individuals for LGB affirmative therapy (LGB-AT) as opposed to traditional treatments. LGB-AT was developed in order to meet the specific treatment needs and preferences of LGB clients, yet the degree to which it accomplishes that objective remains untested. It is important to distinguish LGB-AT, which involve specific mechanisms of change, from ethically affirmative therapy, which is merely ethical practice with LGB clients (Langdridge, 2007). In other words, LGB-AT goes above and beyond therapists' competency for working with LGB clients and respect for their cultural identity, involving unique theory and techniques. LGB-AT requires action taken on the part of the therapist not only to facilitate change in ways designed to the meet the needs of LGB individuals but also to encourage them to embrace their SO (Ritter & Terndrup, 2002).

Harrison (2000) describes core features of LGB-AT, including improving clients' self-worth, particularly related to SO, providing pathways for coping with stigma and prejudice, providing resources for community support, and helping the client find solutions to interpersonal issues related to their LGB status. LGB-AT can also encompass a wide range of therapist roles, including disclosing their own SO and even

becoming involved in political advocacy of LGB rights (Harrison, 2000). In LGB-AT, therapists attempt to minimize any negative emotions such as shame, sadness, or anxiety that have developed from receiving the pervasive messages that same-sex attraction is abnormal or wrong (Shidlo, 1994).

To determine what may drive preferences for LGB-AT and traditional treatments, several constructs that are relevant to the goals and tasks of LGB-AT are examined in this study. Specifically, openness to experience, “outness” (i.e. the degree to which one is open about sexual orientation), social support, perceived heterosexism and internalized homonegativity are examined as predictors of preferences for LGB-AT and traditional treatments. Perhaps more so than in humanistic therapy, individuals with high openness to experience and low perceived social support may be more likely to prefer LGB affirmative therapy –tasks of LGB-AT are to engage in open discussions about the experiences of being a sexual minority and to address lacking social support as a particular risk factor for psychological distress for sexual minorities. Furthermore, given the prominence of open discussions about SO issues in LGB-AT (Harrison, 2000), it stands to reason that LGB-AT would appeal to LGB individuals who are more open about their SO, or “out.” Those who are more comfortable sharing their SO with various peers may be more likely to endorse stronger preferences for LGB-AT. Finally, we predicted that variability in preferences for LGB-AT would emerge depending on participants’ levels of internalized homonegativity and perceived heterosexism. In addition to perceived discrimination from others, those who have more internalized shame and guilt about their SO likely have a greater need for, but lower likelihood of engaging in, an LGB affirmative therapy (Morgan & Eliason, 1992; Robinson, 1994).

To date, there have been no randomized control trials examining the effectiveness of LGB-AT with LGB clients or any psychological treatment designed specifically for LGB clients (Johnson, 2012), nor have any preferences studies been conducted for LGB-AT. In light of this dearth of attention to LGB-AT and to LGB treatment needs generally, and given the benefits of recognizing client preferences, it is important to develop a better understanding of the appeal of LGB-AT to LGB individuals.

Research Objectives and Hypotheses

Objective 1) The present study explores preferences for treatments from different theoretical orientations, as this level of choice likely allows for the identification of preferences based on descriptions that comprehensively represent the overarching theory, aims, and methods of a treatment. The reviewed literature provides theoretical support for the idea that LGB individuals' preferences for traditional treatments may differ from those of heterosexuals, but empirical research is needed. One purpose of the present study is to explore this question.

Hypothesis 1) Heterosexual participants' preferences and LGB participants' preferences for traditional treatments were expected to differ. Specifically, 1A) heterosexual participants were expected to rank CBT as the most preferred and 1B) LGB participants were expected to rank humanistic therapy as most preferred of the three traditional treatments.

Objective 2) The reviewed literature also highlights the potential benefits of LGB affirmative therapy, including making salient the effects of heterosexism on the mental health and well-being of sexual minorities (Ritter & Terndrup, 2002). As LGB-AT has been relatively understudied (Johnson, 2012), it remains unclear whether this treatment is

desirable for its intended recipients. Therefore, the present study tests the extent to which LGB-AT appeals to LGB individuals, and whether it is preferable to traditional treatments.

Hypothesis 2) LGB participants' were expected to rank LGB-AT as more preferred compared to the traditional treatments,

Objective 3) The present study aimed to investigate whether individual demographics and traits interact with sexual orientation to predict choice of traditional treatments.

Hypothesis 3a) General individual characteristics (i.e. perceived social support and openness to experience) were expected to interact with sexual orientation to predict preferential ranking for traditional treatments. Specifically, for LGB individuals, as opposed to heterosexual individuals, as perceived social support decreases and openness to experience increases, the odds of choosing HT as opposed to CBT or PDT were expected to increase.

Hypothesis 3b) General individual characteristics (i.e. perceived social support and openness to experience) as well as LGB-specific traits (i.e. outness; perceived heterosexism; and internalized homonegativity) were expected to predict LGB individual's preferential ranking of LGB-AT and traditional treatments. Specifically, as perceived social support and internalized homonegativity decrease and as openness to experience, outness, and perceived heterosexism increase, the odds of LGB participants choosing LGB-AT as opposed to the traditional treatments were expected to increase.

CHAPTER 2: METHODS

Participants

There were 214 participants in the present study. Participants were undergraduates enrolled in an introductory psychology course at a large Midwestern university who received course credit for their participation as well as survey-takers from Amazon Mechanical Turk who received monetary compensation. Participants were included whether or not they were treatment-seeking. Forty participants were excluded for invalid or insufficient responding, resulting in a final sample of 174 participants (40 undergraduate students and 134 Amazon Mechanical Turk workers). To be considered LGB, participants had to either endorse being lesbian, gay, bisexual, or pansexual on a multiple choice question or endorse a 2 or higher on the Kinsey Scale (Kinsey, Pomeroy, Martin, & Gebbhard, 1953). (Note: Transgender participants were not included in the present study because treatment needs related to gender identity development and experience of cisgenderism may differ from those related to sexual identity development and experience of heterosexism). In order to be considered heterosexual, participants had to endorse being heterosexual on the multiple choice item and endorse a 0 or 1 on the Kinsey Scale. Because the frequency of heterosexual participants was much higher than the frequency of LGB participants in both samples, a “block” method of recruitment was used by which data from each sample was collected in increments of 10 participants. In other words, data collection for the heterosexual sample was stopped at each increment of 10 new participants until the LGB group had accrued the same number of participants as the heterosexual group. In this way, both groups remained approximately the same size over the data collection period.

In the final sample, 51.1% of participants identified as heterosexual according to criteria and 48.9% identified as LGB. Sexual orientation was approximately evenly distributed across the psychology pool participants and the Amazon Mechanical Turk participants. Participants were 50.6% female. Approximately 55.2% identified as White or Caucasian, 2.3% as Black or African American, 35.1% as Asian, 2.9% as Native American, 0.6% as Middle Eastern, and 1.7% as an “other” race/ethnicity or multiracial. Participants had a mean age of 30.4 years ($SD = 11.4$). 43.7% of participants reported that they were currently receiving counseling or had received counseling in the past.

Measures

Treatment Descriptions. The psychodynamic therapy and cognitive-behavioral therapy descriptions were taken directly from Bragesjö and colleagues (2004), who developed the descriptions based on a brochure produced by the Stockholm Regional Health Authority. For that study, “acknowledged experts within each field reviewed and corrected the descriptions” (Bragesjö et al., 2004, p. 298). Each description includes four sections: theory of psychological problems, aims and goals, method and contract, and the role relationship between therapist and client. The PDT description contains 507 words and the CBT description contains 462 words (see Bragesjö et al., 2004 for full descriptions of PDT and CBT). The description of humanistic therapy was written by the author and colleagues based on the existing literature for humanistic therapy. It was assessed qualitatively by identified HT “experts” to determine their perception of its content accuracy. Mirroring the structure of Bragesjö and colleagues’ (2004) descriptions, this description includes four sections: theory of psychological problems, aims and goals, method and contract, and the role relationship between therapist and

client. The HT description contains 535 words (see Appendix A for full description and Table 6 for additional information about expert validation). The description of LGB-AT was written by the author and colleagues based on the existing literature. The description has been assessed qualitatively by identified LGB-AT “experts” to determine their perception of its content accuracy. Similar to the structure of Bragesjo and colleagues’ (2004) descriptions, this description includes four sections: theory of psychological problems, aims and goals, method and contract, and the role relationship between therapist and client. The LGB-AT description contains 549 words (see Appendix B for full description and Table 7 for more information about expert validation).

Rank-Ordering of Traditional Treatment Descriptions. A single item asks participants to rank CBT, PT, and HT in order from most preferred to least preferred.

Rank-Ordering of All Treatment Descriptions. A single item asks LGB participants to rank CBT, PT, HT, and LGB-AT in order from most preferred to least preferred.

Demographics. A short demographics questionnaire was used to gather information on gender, age, sexual orientation, ethnicity/race, religious background, political affiliation, and previous counseling or therapy.

Sexual orientation. The Kinsey Scale (Kinsey et al., 1953) is a single item rated on a 7-point scale, measuring sexual orientation across a continuum, i.e. a dimension representing individuals’ preferences for the same sex, the opposite sex, or falling in between with preference for both. It has been referred to as “the most widely used measure of sexual orientation” (Bailey, 2009). The scale ranges from 0, identifying as exclusively heterosexual, to 6, identifying as exclusively homosexual. The Kinsey Scale

has established good construct validity (Ornelas, 1993), converging with the Multidimensional Scale of Sexuality (MSS; Berkey, Perelman-Hall, & Kurdek, 1990).

Outness. The Outness Inventory (OI; Mohr & Fassinger, 2000) is an 11-item measure rated on a 7-point Likert scale intended to measure the degree to which LGB individuals are open about their SO in the context of different social relationships. Responses on OI items indicate the degree to which the respondent's SO is known by and openly discussed with various others. There are three subscales that indicate the degree to which one is: 1) out to family, 2) out to the world, 3) out to religion. Each of these subscales is scored by averaging the items in that subscale, and a total outness score is calculated by averaging the three subscales. An example item is "*How open you are about your sexual orientation to work peers?*" The OI demonstrated high internal consistency and good convergent validity with measures of desire to hide SO and fear of judgment from others regarding SO (Cronbach's $\alpha = 0.87$; Mohr & Fassinger, 2000). The OI has an internal consistency of Cronbach's $\alpha = 0.90$ in the present study.

Internalized Homonegativity. The Internalized Homonegativity Inventory (IHNI; Mayfield, 2001) is a 23-item measure of negative internalized feelings about being LGB rated on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). Exploratory and confirmatory factor analyses revealed that items loaded onto three factors: (a) *Personal Homonegativity*, (b) *Gay Affirmation* (reverse-coded), and (c) *Morality of Homosexuality* (Mayfield, 2001). Subscales are calculated by summing the items in that subscale, and a total score is calculated by summing all items. An example item is "*I sometimes feel that my homosexuality is embarrassing.*" Internal consistency was good, with a Cronbach's α of 0.91 for the overall scale and alphas

ranging from .70 to .89 for the three subscales. Mayfield (2001) also reported convergent and discriminant validity for the IHNI; for instance, it predicts attitudes towards homosexuality (NHAI; Nungesser, 1983) and is negatively related to homosexual identity development (GIQ; Brady & Busse, 1994). The IHNI has an internal consistency of Cronbach's $\alpha = 0.88$ in the present study.

Openness to Experience. The Acceptance and Action Questionnaire-Second Edition (AAQ-II; Bond et al., 2011) is a revised 10-item measure of acceptance, experiential avoidance, and psychological inflexibility rated on a seven-point scale ranging from 1 (never true) to 7 (always true). AAQ-II total scores are determined by reverse scoring the appropriate items, then summing all items. An example item from this measure is *“My painful experiences and memories make it difficult for me to live a life that I would value.”* Internal consistency was good, with an alpha of .84, and the instrument appears to demonstrate appropriate convergent validity related to the Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004), as well as the White Bear Suppression Inventory (Wegner & Zanakos, 1994) (Bond et al., 2011). The AAQ-II has an internal consistency of Cronbach's $\alpha = 0.73$ in the present study.

Psychological Distress. The Depression Anxiety Stress Scales – Short Form (DASS-21; Lovibond & Lovibond, 1995) is a 21-item self-report measure of depression, anxiety, and stress. Items are rated on a scale of 0 to 3 (“never” to “almost always”). To compute subscale (*Depression*, *Anxiety*, and *Stress*) scores, items in that subscale are summed, and to compute a total score, all items are summed. Subscales scores and total scores are then multiplied by two. Higher scores indicate higher levels of distress. An example item for depression from the DASS-21 is *“I felt that life was meaningless.”* The

DASS-21 has strong convergent validity, correlated with the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), and the Personal Disturbance Scale (Bedford & Foulds, 1978) and an internal consistency of .93 (Henry & Crawford, 2005, p. 236). The DASS-21 has an internal consistency of Cronbach's $\alpha = 0.95$ in the present study.

Perceived Heterosexism. The Gay and Lesbian Oppressive Situations Inventory – Effect scale (GALOSI-E; Highlen, Bean, & Sampson, 2000) is a 47-item scale of the GALOSI and assesses the effect of perceived heterosexism and discrimination on gay and lesbian individuals across a variety of situations. Items are rated on a 5-point Likert-type scale ranging from 1 (never) to 5 (almost always). An example item is “*People have avoided me because of my gayness.*” The measure is comprised of seven subscales: 1) *Couples Issues*, 2) *Dangers to Safety*, 3) *Exclusion, Rejection, & Separation*, 4) *Internalized Homonegativity*, 5) *Restricted Opportunities & Rights*, 6) *Stigmatizing & Stereotyping*, and 7) *Verbal Harassment & Intimidation*. Subscales are calculated by summing items in that subscale and total scores are the sum of all items. Higher scores signify more perceived discrimination. Discriminant validity was determined by comparison of the GALOSI-E with the Impression Management Scale, a measure of social desirability (Paulhus, 1991), which revealed no relationship. Internal consistency for the subscales ranged from .63 to .88. Criterion validity was supported through a group difference procedure revealing a large gender effect (Highlen et al., 2000). The GALOSI-E has an internal consistency of Cronbach's $\alpha = 0.98$ in the present study.

Perceived Social Support. The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) is a 12-item measure

developed to assess individuals' perceived levels of social support. Total and subscale scores range from 1 to 7, with higher scores suggesting greater levels of perceived social support. A principal components analysis supported the three-factor structure of the measure indicating social support from: 1) *Family*, 2) *Friends*, and 3) *Significant others* (Dahlem, Zimet, & Walker, 1991). Subscale scores are computed by averaging the items in that subscale and total scores are computed by averaging all items. The instrument demonstrated good internal consistency (Dahlem et al., 1991). An example item is "*I can count on my friends when things go wrong.*" The MSPSS has an internal consistency of Cronbach's $\alpha = 0.92$ in the present study.

Help-Seeking. The Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Welse, 1975) is a 17-item, self-reported questionnaire that asks respondents to rate how likely they would be to seek counseling services if they were experiencing problems related to three areas comprising three subscales: *Psychological and Interpersonal Concerns*, *Academic Concerns*, and *Drug Use Concerns*. The likelihood of seeking counseling services was rated on a Likert-type scale ranging from 1 (very unlikely) to 6 (very likely). To calculate subscale scores, items in that subscale are averaged, and to calculate total scores, all items are averaged. Higher scores signifying a higher likelihood of seeking services. Adequate internal consistency (Demyan & Anderson, 2012; Vogel & Wester, 2003) and acceptable convergent validity with attitudes toward help-seeking (Kelly & Achter, 1995) have been established for the ISCI. An example item asks the respondent to report the likelihood they would see a therapist for "*difficulties with friends.*" The ISCI has an internal consistency of Cronbach's $\alpha = 0.92$ in the present study.

Procedures

All measures and procedures were completed online using a research management system. In this design, all participants were presented with the three standard treatment descriptions of: PT, HT, and CBT. The order of the presentation of the descriptions was randomized in order to reduce order effects and their potential influence on the primary findings. After reading the three descriptions, all participants were asked to rank-order the treatments in terms of most preferred to least. LGB participants then read the LGB affirmative therapy description and were asked to rank order the treatments again, this time including LGB affirmative therapy in a ranking of the four treatments. All participants then completed the demographic questionnaire, the DASS-21, the Kinsey Scale, the AAQ-II, the MSPSS, and the ISCI. LGB participants additionally completed the OI, the IHNI, and the GALOSI-E. Data was analyzed using multinomial logistic regression analyses, Chi Square analyses, independent sample t-tests, and bivariate correlations.

Procedures for Developing Content of LGB-AT and Humanistic Descriptions

Each treatment description is approximately the same length in terms of number of words (each falls between 460 and 550 words) and contains the same four subsections: Theory of psychological problems (e.g. for PDT, problems stem from inner conflicts), Aims and goals (e.g. for LGB-AT, to affirm LGB identity), Method and contract (e.g. for CBT, cognitive restructuring of maladaptive thoughts), and Role relationship between client and therapist (e.g. for HT, therapist is non-directive and client is in control of the session).

The LGB affirmative therapy and HT descriptions were sent to identified “experts” in each type of therapy who rated the descriptions for their perceptions of content validity. Experts were identified as psychologists who have substantial experience in research and/or practice with the specific treatment they were asked to rank. Raters were considered experts in humanistic therapy because they included a former president of the APA Division of Humanistic Psychology (Div. 32), a leading authority on the topic of empathy, authors of books, chapters and articles on HT, and practitioners specializing in HT. Raters were considered experts in LGB affirmative therapy by the fact that they included researchers specializing in therapy with LGB clients, authors of books and journal articles about LGB-AT and the impact of heterosexism on mental health. Early in the process of developing the descriptions, experts provided substantial qualitative feedback on the content of the descriptions and made suggestions for including or excluding components or for wording changes.

All respondents were asked to rate: (1) how accurately the description represents the therapy, (2) how much the descriptions matches their professional conceptualization of the therapy, and (3) how much the description is readable/easily understood by undergraduates, on a scale ranging from 0 (“not at all”) to 6 (“to a very great extent”). If substantial changes were made to a draft after a rating had been provided, respondents were asked to re-rate the new version of the description. The LGB-AT description has been evaluated by six experts in LGB affirmative therapies. Ratings indicate that the LGB-AT description represents the goals described. Ratings of the accuracy of the description ($M = 4.83$; $SD = 0.75$), match to professional conceptualization ($M = 4.50$, $SD = 1.22$), and readability ($M = 5.00$, $SD = 0.63$) fell in the intended range (i.e. greater than

4, which represented “fair” accuracy, match, and readability), indicating that the respondents considered it an appropriate description for the purposes of the study. The humanistic description was evaluated by seven experts in humanistic therapy. Ratings from indicate the accuracy of the description ($M = 4.71$; $SD = 0.95$), match to professional conceptualization ($M = 4.71$, $SD = 0.95$), and readability ($M = 4.86$, $SD = 0.90$) also fell within the intended range. Individual expert rating data is presented in Tables 6 and 7.

CHAPTER 3: RESULTS

Descriptive statistics for variables are presented in Tables 1 and 2. No significant racial or ethnic differences emerged across treatment rankings.

Pearson chi square analyses were used to test which treatments were ranked as the top choice more frequently than the other treatments. The omnibus test for the difference in ranking of the three treatments for all participants was significant, $X^2(2, 167) = 20.35$, $p < .001$. Pairwise comparisons were conducted to detect relationships among preference rankings for each treatment. Bonferroni correction was used to control for familywise Type I error. Adjusted alpha was equal to 0.17. There was no significant difference in preference between CBT and HT, $X^2(1, 137) = 2.11$, $p = .146$. However, PDT was ranked as the top choice less frequently compared with both CBT and HT (CBT > PDT, $X^2(1, 90) = 10.00$, $p < .01$; HT > PDT, $X^2(1, 107) = 20.65$, $p < .001$).

Sexual Orientation and Treatment Preferences

The first aim of the present study was to examine the association between sexual orientation and treatment preferences. It was found that sexual orientation was not related to the top choice of the three traditional treatments when examining the overall sample, $X^2(2, 160) = 2.49$, $p = .288$. Because this analysis may not have had enough power to detect an effect (given that some cells contained a small number of participants), follow up chi square analyses were conducted for the heterosexual group alone and for the LGB group alone to determine if a different pattern of preferences emerged between groups.

When the heterosexual group and the LGB group were each examined in isolation, differences in treatment choice emerged. Heterosexual participants' pattern of

top treatment choice was comparable to that of the overall sample. The omnibus test was significant, $X^2(2, 87) = 10.41, p < .01$. Pairwise comparisons revealed that PDT was again chosen the least (CBT > PT, $X^2(1, 49) = 7.37, p < .01$; HT > PDT, $X^2(1, 53) = 9.98, p < .01$). Further, there was no difference between preferences for CBT and HT for heterosexuals, $X^2(1, N = 72) = 0.22, p = .637$. Thus, Hypothesis 1A (i.e. that CBT would be the most preferred treatment for heterosexuals) was not completely supported.

When the rankings were examined with LGB participants alone, a slightly different pattern of results surfaced. The omnibus test again revealed differential preferences among the treatments, $X^2(2, N = 84) = 14.86, p < .01$. LGB participants preferred HT to both CBT and PDT (HT > CBT, $X^2(1, N = 68) = 5.88, p < .017$; HT > PDT, $X^2(1, N = 60) = 13.07, p < .001$). Preference rankings for CBT were no different than those for PDT, $X^2(1, N = 40) = 1.60, p = .206$. Thus, Hypothesis 1B, that LGB individuals would prefer HT to both CBT and PDT, was supported (see Table 3).

Preferences for LGB Affirmative Therapy

The second aim pertained to LGB participants' preferences for LGB-AT as compared to traditional treatments. The omnibus test for LGB participants' ranking of the four treatments (CBT, HT, PDT, LGB-AT) was significant, $X^2(3, 67) = 11.27, p < .05$. Pairwise comparisons were conducted to detect relationships among preference rankings for each treatment. Bonferroni correction was again used to control for familywise Type I error. Adjusted alpha was equal to 0.17. There was no difference between LGB participants' rankings of LGB-AT and any of the traditional treatments, (LGB-AT = CBT, $X^2(1, 36) = 0.11, p = .739$; LGB-AT = HT, $X^2(1, 42) = 1.52, p = .217$; LGB-AT = PDT, $X^2(1, 23) = 5.26, p = .022$). Therefore, Hypothesis 2, that LGB

participants would prefer LGB-AT to the traditional treatments in the second treatment ranking, was not supported (see Table 4).

From the first ranking to the second ranking, 68.5% of LGB participants retained their original choice. LGB individuals' rankings for each of the three traditional treatments remained fairly consistent across the two rankings (CBT, $\rho_s = 0.80, p < .05$; HT, $\rho_s = 0.71, p < .05$; PDT, $\rho_s = 0.74, p < .05$). Thus, LGB participants' first rankings of treatment preference were not substantially different from the second rankings.

Predictors of Preferences

To address Hypothesis 3a, multinomial logistic regression analyses were employed to determine whether individual characteristics (i.e. sexual orientation, perceived social support [MSPSS] and openness to experience [AAQ-II]) predicted which “traditional” treatment (i.e. CBT, HT, PDT) participants ranked as most preferred. Given the purpose of the study was to examine differences in preferences based on sexual orientation, each of the two-way interactions between SO and the other two predictors were added to the initial model along with the main effects of the eight predictors. Gender, prior therapy, psychological distress (DASS-21), and intention to seek counseling (ISCI) differed across the two sexual orientation groups and were thus included as covariates in the model. The omnibus test of this initial model was statistically significant, $G^2(30, N = 148) = 59.73, p < .01$, *Cox and Snell's* $R^2 = .332$, *Nagelkerke's* $R^2 = .381$. Non-significant predictors were then sequentially removed from the model.

In the final model, sexual orientation, openness to experience, and the interaction between sexual orientation and openness to experience remained significant and were retained, $G^2 (12, N = 149) = 38.94, p < .001$, *Cox and Snell's* $R^2 = .230$, *Nagelkerke's* $R^2 = .264$. The odds that a heterosexual individual chose HT over PDT were greater than the odds that an LGB individual chose HT over PDT, $Wald X^2 (1, N = 149) = 5.64, p < .05$, $OR = 355.09$. Additionally, the odds that a heterosexual individual chose HT over CBT were greater than the odds that an LGB individual chose HT over CBT, $Wald X^2 (1, N = 149) = 8.52, p < .01$, $OR = 304.93$. The choice of CBT as opposed to PDT was unrelated to sexual orientation, $p > .05$.

After controlling for the other variables, an individual's openness to experience significantly predicted treatment choice. As AAQ-II scores increase, the odds of choosing HT over PDT increase, $Wald X^2 (1, N = 149) = 7.72, p < .01$, $OR = 1.16$ and the odds of choosing HT over CBT increase, $Wald X^2 (1, N = 149) = 5.71, p < .05$, $OR = 1.11$. The odds of choosing PDT as opposed to CBT are unrelated to openness to experience, $p > .05$.

Finally, the only significant interaction to emerge in the model was sexual orientation by openness to experience. For LGB participants, as opposed to heterosexual participants, as openness to experience increases, the odds of choosing HT as the top choice over CBT increase, $Wald X^2 (1, 149) = 9.88, p < .01$, $OR = 1.14$ and the odds of choosing HT over PDT increase, $Wald X^2 (1, 149) = 5.31, p < .05$, $OR = 1.14$ (see Table 5).

To address Hypothesis 3b, multinomial logistic regression analyses were also used to determine whether the general individual characteristics as well as LGB-specific

individual characteristics predicted the second treatment ranking for LGB participants.

The initial model included: perceived social support; openness to experience; outness; internalized homonegativity; and perceived heterosexism. Once again, gender; prior therapy; psychological distress; and intent to seek counseling were added as covariates.

The omnibus test for this model was significant, $G^2(39, N = 46) = 58.33, p < .05$, *Cox and Snell's* $R^2 = .719$, *Nagelkerke's* $R^2 = .772$. Non-significant predictors were then removed one at a time. In the final model, none of the predictors of the second treatment ranking were significant, $p's > .05$.

CHAPTER 4: DISCUSSION

In the present study, humanistic therapy and cognitive behavioral therapy were preferred overall to psychodynamic therapy. Similarly, heterosexual participants preferred both HT and CBT to PDT, and did not have differential preferences for CBT and HT. This is contrary to what was predicted, that CBT would be preferred by heterosexual participants to the other two traditional treatments. This hypothesis was grounded in past research with more general (i.e. predominantly heterosexual) samples which reported preferences for cognitive behavioral interventions to treatments stemming from other theoretical orientations (e.g. Becker et al., 2007). Because few past preference studies have included HT as a potential treatment choice, it is possible that it is as appealing as CBT, but this possibility has gone relatively untested prior to this study. It may also be the case that the sample obtained in the present study was fundamentally different from the samples obtained in past research which spurred hypothesis 1a - many of the studies examining preferences for treatments stemming from different theoretical orientations involved predominantly White participants or participants who were in treatment or treatment-seeking.

Moreover, as predicted, LGB participants preferred HT to CBT and PDT. This preference may have been due to the open exploration and client focus that characterizes HT. Topics of discussion in HT are largely directed by the client, which may allow for a more personalized treatment that takes the individual experience into account. In a heterosexist society in which the voices of sexual minorities have been suppressed (Mayberry, 2013; Hernandez, 2012), it is not surprising that LGB individuals would prefer HT -- the client-focus of HT gently encourages clients to disclose experiences that

have been suppressed but does not pathologize and label psychological problems. In this way, clients may feel less judged or stigmatized in HT than they might in other types of therapies. As Rogers (1951) stated, HT is predicated on the assumption that clients come to therapy with low self-esteem, which is a direct result of messages that their experiences are unacceptable. Furthermore, traditional Rogerian humanistic therapy promotes clients' self-expression and positive regard for the self even when discouraged by conventional societal messages (Rogers, 1951) – an aspect of treatment which may be particularly appealing to oppressed groups like sexual minorities. Whereas CBT might encourage changing thoughts and behaviors in order to improve and PDT involves therapists delivering their interpretations about client experiences,' HT may provide a unique opportunity for LGB clients to explore their experiences in an accepting, nonjudgmental environment.

This theory may be further supported by the finding that openness to experience interacted with sexual orientation to predict top treatment choice. For LGB individuals, as opposed to heterosexual individuals, the odds of choosing HT over the other two traditional treatments increases as openness to experience increases. This suggests that the open, explorative nature of humanistic therapy is an important quality that makes it more appealing to LGB individuals. One implication of these results, if replicated, is that therapists might consider HT as a desirable option for LGB clients who appear higher on openness to experience. Alternatively, a therapist might incorporate interventions of open exploration of experience into therapy as usual.

As the present study suggests that heterosexual individuals may find HT no less preferable than CBT, and that LGB clients may actually prefer HT to CBT and PDT,

perhaps more attention should be given to understanding why HT might be a desirable treatment. Given that CBT was preferred (along with HT) among heterosexuals, it might be that clients prefer multiple choices for treatment, which points to the importance of psychotherapy training and practice from diverse theoretical orientations (Levy & Anderson, 2013; Anderson, Levy, Heckman, McCarrick & Perlman, 2015). Maintaining multiple treatment options grant clients some choice in the treatment they receive which, as discussed, is encouraged by the APA (2006) and beneficial for treatment outcome (Constantino et al., 2011; Swift & Callahan, 2009).

Surprisingly, LGB participants did not appear to prefer LGB Affirmative Therapy to any of the traditional treatments as hypothesized; LGB-AT was not ranked as the top choice any more so than CBT, HT, or PDT. Because LGB-AT is designed to meet the special treatment needs of LGB clients, it remarkable that LGB-AT would not be preferable to treatments that do not involve tasks and goals specific to LGB concerns.

Some theorists have postulated that a treatment which places too much emphasis on sexual orientation could be perceived by LGB people as patronizing or compartmentalizing of their individual experiences (Fassinger & Arseneau, 2007; Silverberg, 1984). Moreover, some suggest that LGB affirmative therapy as it currently exists may not adequately address the needs of the heterogeneous LGB community across stages of sexual identity development (Bennett & Douglass, 2013). Specifically, societal changes may require a shift in the therapy process for LGB clients. As suggested by Bennett and Douglass (2013), fewer clients may require an intense focus on coming out and identity crises because society has become more accepting -- honing in on these issues in treatment may result in other important needs being overlooked. Furthermore,

urging clients to affirm or assert an LGB identity may inadvertently lead clients to “adopt a false self-narrative” (Bennett & Douglass, 2013, p. 285). In other words, clients may conform to an identity that the therapist, potentially through a biased lens, has created for them, rather than autonomously uncovering a genuine sense of self. Perhaps LGB individuals would be more likely to choose LGB-AT over other types of treatment if it was more attuned to the diversity within sexual minorities’ experiences.

Accordingly, it was expected that LGB individuals would vary in their preferences for LGB affirmative therapy based on treatment-relevant characterological traits. However, out of the many predictors explored in the model for the second treatment ranking, none emerged as significant. In light of their theoretical connections to the features of LGB affirmative therapy, it was surprising that constructs such as openness to experience, perceived social support, levels of outness, perceived heterosexism, and internalized homonegativity did not predict whether an individual would choose LGB-AT over the traditional treatments. Perhaps this finding suggests LGB-AT, despite its intended purpose of addressing these issues, is lacking in some fundamental way such that individuals experiencing the issues do not perceive LGB-AT as a preferred treatment for addressing them. However, it is more likely that the constructs did not predict preferences for LGB-AT because LGB-AT was not the preferred treatment of LGB individuals in this study.

As societal attitudes towards sexual minorities change, perhaps therapies intended to address the needs of these individuals must shift as well. When LGB-AT was first conceptualized in the 1980s and 1990s, heterosexism and anti-LGB attitudes were much more prominent than they are today (Baunach, 2012; Taylor, 2013). Perhaps at that time,

it was more appropriate for therapy with LGB clients to consistently provide an intense focus on the ways in which societal oppression and isolation were impacting LGB clients' mental health because these problems were more overt and monolithic than they are today (Bennett & Douglass, 2013). For example, past theories of LGB identity (e.g. Bayer, 1981; Clark, 1987; Cass, 1996; Davies, 1996) described a somewhat uniform LGB experience. Comparatively, modern conceptualizations of LGB identity are more nuanced, acknowledging that LGB individuals' experiences vary across stages of identity development (Peacock, 2000; Roseborough, 2003, Bennett & Douglass, 2013), with respect to other aspects of cultural identity such as racial and gender identity (Hill, 2013; Schippers, 2000), and other aspects of each individual's unique life circumstance.

In the context of therapy, shifting conceptualizations of sexual identity and the experience of the LGB individual call for more nuanced and individually-focused interventions for LGB clients. As suggested by Sue and Sue (2012) in the context of racial diversity, the therapist's awareness and facilitation of discussions about the impact of societal oppression and discrimination on each individual client's experience is an important part of therapy with cultural minorities. They purport that the individual is the focus of treatment and that the therapist should be aware of the cultural context which gave rise to the individual's current life circumstances (Sue & Sue, 2012). Perhaps this is an area in which LGB affirmative therapy could be developed – rather than uniformly engaging in discussions about discrimination and oppression with all minority clients (e.g. Cardemil & Battle, 2003; Harrison, 2000; Shidlo, 1994), more emphasis might be placed on understanding each client's experience as a culmination of many contextual factors.

Limitations

Several limitations of the present research should be noted. Firstly, given that the study included two primary aims, to determine both whether LGB individuals' preferences differed from those of heterosexual individuals and whether LGB individuals preferred LGB-AT to traditional treatments, our design was such that the LGB participants made two separate treatment rankings. It is possible that this design created a demand characteristic, swaying participants to choose LGB-AT over the other treatments. However, LGB-AT was not ranked higher than any other treatment, so if a demand characteristic was present, it was not enough to make LGB-AT the top-ranked treatment. It could also be that because participants had made a selection of a treatment in the first ranking, they felt a commitment to "stick with" the traditional treatment they had already chosen. Indeed, a majority of LGB individuals retained the treatment selected as most preferred from the first ranking to the second, which may have contributed to the low frequency with which LGB-AT was ranked as the top choice. Future research might improve on the methodology of the present study by soliciting only one treatment ranking from participants, or by utilizing a between-group design in which each LGB participant receives only one treatment description to rate, rather than to rank.

The sample obtained was somewhat limited in that it was mostly comprised of White and Asian participants between the ages of 18 and 30. Therefore, the results may not be generalizable to individuals who are not White or Asian, or individuals of different age ranges. The sample was predominantly comprised of individuals from Amazon Mechanical Turk. There was some advantage to this in that it allowed us to obtain data

from a more diverse sample in terms of age, gender, and race. However, this may also be a limitation in that our sample was very demographically different in terms of ethnicity to the population in the United States. Furthermore, a treatment-seeking sample was not selected for this study. Thus, the results may not generalize to potential clients are actually seeking treatment and to whom treatment preferences are most relevant.

Finally, it is difficult to know the extent to which the design of this study allowed us to truly capture participants' preferences. One issue to consider is whether participants learned enough about each treatment from approximately 500-word written descriptions to make an informed choice. In a clinical context, clients may be able to make preferences known to the therapist if they are presented with options in some format, whether via questionnaires and rating scales, written or audiovisual descriptions, the therapist presenting options verbally prior to the start of treatment, or having had prior therapy. We chose to use written descriptions in this study for practical purposes. Though the descriptions were rated and approved by experts in each treatment area, the content validity of the descriptions could be further established. Moreover, it is difficult to know whether the use of written descriptions may have resulted in participants reporting preferences for superficial reasons (such as familiarity with the name of a treatment).

Future Directions

Based on a review of the literature, it was determined that LGB affirmative therapy targeted the treatment needs of LGB individuals, but not the more specific needs of transgender or other trans* individuals. For that reason, trans* individuals were not included in the present study. The field would benefit from expansion and investigation

of treatments designed to help trans* individuals navigate their unique identity development and tolerate cisgenderism they are sure to experience.

Future research is needed to determine which types of treatment are most preferable and credible to LGB individuals in order to ensure that this underrepresented group receives mental health care tailored to their needs. Specifically, future studies may further examine the extent to which LGB-AT appeals to LGB participants or aim to determine what aspects of LGB-AT sexual minorities find credible and preferable such that these aspects may be incorporated into treatment as usual.

Arguably, although identifying which of the most common treatments are most preferred by members of various diverse groups provides useful information to providers, discerning methods for adapting existing treatments for use with diverse clients is more useful still. Cultural adaptation refers to the process of modifying existing treatments such that they are consistent with the values, beliefs, and patterns within the client's culture (Bernal, Jiménez-Chafey, & Rodríguez, 2009). Several scholars have presented guidelines for adapting therapies to accommodate cultural context (e.g. Lau, 2006, Barrera & Castro, 2006; Hwang, 2009). These include identification and targeting of culturally-specific risk factors (e.g. discrimination) and the utilization of protective factors (e.g. close familial ties) for clinical problems, as well as the modification of interventions for specific groups (e.g. exposures tailored to the unique experiences of refugees; Lau, 2006, see also Barrera & Castro, 2006; Hwang, 2009). Perhaps theorists and researchers could further develop guidelines for adapting treatment as usual to accommodate the needs of LGB individuals.

Given recent research suggesting that LGB-AT is a bit outdated (e.g. Bennett & Douglass, 2013), theorists and researchers could modify the treatment so that it is more applicable with LGB clients in the present day. As society continues to evolve in its attitude toward and treatment of the LGB community, so too may LGB clients' therapy needs evolve and change. Perhaps LGB affirmative therapy, rather than being implemented as a stand-alone treatment, should instead refer to an approach to treatment adaptable to the individual client's experience, and only used with those LGB clients who require or prefer it.

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Table 1

Participant Characteristics According to Sexual Orientation Group (n = 174)

	<i>M (SD)</i>		
	Heterosexual (n = 89)	LGB (n = 85)	Total (n = 174)
<i>Demographic Data</i>			
Age	31.1 (13.2)	29.6 (9.1)	30.4 (11.4)
Gender (Female)	59.6%	41.2%	50.6%
Race (White)	64.0%	45.9%	55.2%
Kinsey	1.16 (0.4)	4.12 (2.3)	2.6 (2.2)
Prior Therapy	36.0%	51.8%	43.7%
Depression, Anxiety, Stress			
Scales – 21 (DASS-21)	73.1 (23.1)	86.2 (27.5)	79.1 (25.9)
Depression Subscale	24.2 (10.0)	28.5 (10.3)	26.2 (10.3)
Anxiety Subscale	23.0 (8.0)	26.9 (10.0)	24.8 (9.2)
Stress Subscale	26.0 (8.5)	30.5 (10.0)	28.1 (9.4)
Intentions to Seek Counseling			
Scale (ISCI)	3.1 (1.0)	3.4 (0.9)	3.3 (1.0)
Interpersonal	3.2 (1.1)	3.6 (1.0)	3.4 (1.1)
Academic	2.7 (1.1)	3.0 (1.1)	2.9 (1.1)
Drug	3.7 (1.6)	3.6 (1.4)	3.6 (1.5)
Multidimensional Scale of Perceived			
Social Support (MSPSS)	5.4 (1.1)	5.1 (0.9)	5.2 (1.0)
Family	5.5 (1.3)	4.8 (1.2)	5.2 (1.3)
Friends	5.1 (1.5)	5.1 (1.2)	5.1 (1.4)
Significant Other	5.5 (1.4)	5.2 (1.3)	5.4 (1.3)
Acceptance and Action Questionnaire			
(AAQ-II)	47.3 (11.9)	43.5 (8.6)	45.5 (10.6)

Note. Presents percentages / means (and standard deviations) for participants' traits and characteristics

Table 2

Percentages / Means (and Standard Deviations) for LGB-AT Related Individual Characteristics (n =85)

The Outness Inventory (OI)	3.8 (1.5)
Family	4.1 (1.7)
World	3.6 (1.8)
Religion	3.2 (2.0)
Gay and Lesbian Oppressive	
Situations Inventory -Effect (GALOSI-E)	118.2 (42.4)
Couples Issues (CI)	7.6 (3.2)
Dangers to Safety (DS)	14.1 (6.2)
Exclusion, Rejection, Separation (ERS)	24.9 (9.8)
Internalized Homonegativity (IH)	22.7 (9.2)
Restricted Opportunities and Rights (ROR)	6.3 (3.3)
Stigmatizing and Stereotyping (SS)	20.5 (7.5)
Verbal Harassment and Intimidation (VHI)	21.1 (7.6)
Internalized Homonegativity Inventory	
(IHNI)	65.2 (21.4)
Personal Homonegativity (PH)	32.7 (14.2)
Gay Affirmation (GA)	19.8 (6.0)
Morality of Homosexuality (MOH)	13.0 (7.3)

Table 3

Summary of Chi Square Analyses for Top Ranked Choice of Traditional Treatments for Overall Sample (n = 171)

Treatment pairs	χ^2 Values		
	Heterosexual (n = 87)	LGB (n = 85)	Total (n = 171)
CBT (39.1%) v. HT (43.7%)	0.22	5.88*	4.11
HT (43.7%) v. PDT (17.2%)	9.98*	13.07*	23.02*
CBT (39.1%) v. PDT (17.2%)	7.37*	1.60	8.19*

Note. Frequencies of selecting each treatment as top choice are shown in parentheses.
CBT = Cognitive Behavior Therapy, HT = Humanistic Therapy, PDT = Psychodynamic Therapy

*Indicates significant differences, $p < .017$.

Table 4

Summary of Chi Square Analyses for LGB Individuals' Top Ranked Choice of LGB-AT and Traditional Treatments (n = 73)

Treatment	χ^2
LGB-AT (24.7%) v. CBT (28.8%)	0.23
LGB-AT (24.7%) v. HT (37.0%)	1.80
LGB-AT (24.7%) v. PDT (9.6%)	4.84
CBT (28.8%) v. HT (37.0%)	0.75
CBT (28.8%) v. PDT (9.6%)	7.00*
HT (37.0%) v. PDT (9.6%)	11.77*

Note. Frequencies of selecting each treatment as top choice are shown in parentheses.

CBT = Cognitive Behavior Therapy, HT = Humanistic Therapy, PDT = Psychodynamic Therapy, LGB-AT = LGB Affirmative Therapy

*Indicates significant differences, $p < .0083$.

Table 5

Summary of Multinomial Logistic Regression Analysis for Predicting Top Treatment Choice of CBT, HT, or PDT (n=149)

Variable	CBT v. PDT			HT v. PDT			HT v. CBT		
	B	SE	OR	B	SE	OR	B	SE	OR
Gender ^a	-2.01**	0.59	0.13	-0.41	0.53	0.66	1.60**	0.47	4.94
SO ^b	0.15	2.47	1.17	5.87*	2.47	355.09	5.72**	1.96	304.93
DASS	0.03*	0.01	1.03	0.03*	0.01	1.03	-0.01	0.01	0.99
AAQII	0.05	0.05	1.05	0.15**	0.05	1.16	0.10*	0.04	1.11
SOxAAQII	0.01	0.06	1.01	-0.13*	0.06	0.88	-0.14**	0.04	0.87

^aGender was dummy coded with Female as the reference category

^bSO was dummy coded with LGB as the reference category

*p < .05 **p < .01

Table 6

Expert Information and Ratings for Humanistic Therapy Description (n = 8)

Name	Rating		
	A	B	C
Expert 1	5	5	5
Expert 2	5	5	4
Expert 3	5	5	4
Expert 4	4	4	6
Expert 5	3	3	5
Expert 6	5	5	4
Expert 7	6	6	6
Expert 8	5	5	6
Means	4.75	4.75	5.00

Note. A = Accuracy, B = Professional Conceptualization, C = Readability

Ratings are made on a scale from 0 to 6.

Experts include: Arthur Bohart, Ph.D., David Weibel, Ph.D., Larry Leitner, Ph.D., William Stiles, Ph.D. Sarah Knox, Ph.D., Lynn Angus, Ph.D., Lara Honos-Webb, Ph.D., Timothy Anderson, Ph.D.

Table 7

Expert Information and Ratings for LGB Affirmative Therapy Description (n = 6)

Name	Rating		
	A	B	C
Expert 9	4	3	5
Expert 10	5	5	4
Expert 11	5	3	5
Expert 12	4	5	5
Expert 13	5	5	5
Expert 14	6	6	6
Means	4.83	4.50	5.00

Note. A = Accuracy, B = Professional Conceptualization, C = Readability

Ratings are completed on a 0 to 6 scale.

Experts include: John Pachankis, Ph.D., Heather Lyons, Ph.D., Kathleen Ritter, Ph.D., Heidi Levitt, Ph.D., Debra Hope, Ph.D., Catherine Crisp, Ph.D.

APPENDIX A: HUMANISTIC THERAPY DESCRIPTION

Humanistic Therapy

Theory of psychological problems

Humanistic therapy considers psychological distress to be a product of the disruption of human psychological growth, resulting in a reduced ability to learn and benefit from experience. Some forms of humanistic therapy focus on human suffering as the result of natural aspects of the human condition, such as the “existential” realities of death, freedom, meaning, and responsibility. The knowledge that life is impermanent and that opportunities are fleeting can create negative emotions like guilt. However, according to this school of thought, psychological distress can serve an adaptive function as well, alerting people to address their internal need to grow and change. Emphasis is therefore placed on regarding the client as a whole person, rather than on addressing any particular symptoms or problems. Humanistic therapy originates from Carl Rogers’ (1951) client-centered therapy.

Aims and goals

The aim of humanistic therapy is to reinforce clients’ beliefs that they are in control of their lives and already have the tools to cope with their problems. Clients progress towards self-actualization by learning to attend to their experiences, rather than by removing “pathological” or “disordered” distress.

Method and contract

Humanistic therapy does not have a standard number of sessions though it often lasts over 20 sessions. Sessions are typically held at regular intervals at the therapist's office, and each lasts about an hour. In humanistic therapy, change is thought to occur when clients gravitate towards self-actualization and begin to realize their full potential as human beings. Therefore, when clients are granted freedom to make their own choices, they tend to choose paths that allow them to grow and become more enriched and satisfied. Clients' experiences and emotions are explored and discussed in therapy, usually with fewer interpretations or directive attempts by therapists to "solve" a specific problem. Rather, the goal is for clients to increase self-esteem by trusting their own experiences and working to attain goals that are in line with each client's individual values and lifestyles.

Humanistic therapy environments are characterized by the therapist's honesty, caring, warmth, optimism, and understanding of the client, and facilitate clients' comfortable exploration of their self-concepts and their emotions. Clients' natural abilities to change the way they perceive their identity, meaning in life, and psychological problems, even in the worst circumstances, can then emerge. Humanistic therapy also emphasizes how clients can become more confident in their feelings. Therapists assist clients in developing awareness about how they perceive themselves, their feelings, and their circumstances and about how changing this perception can lead to change in behavior.

Role relationship between therapist and client

In humanistic therapy, the relationship between the client and therapist is a healing element and an opportunity for growth in and of itself. This relationship is collaborative. Most humanistic therapists are "non-directive" and recognize clients' wishes for

determining the topics of discussion. Some humanistic therapists, however, may be somewhat more directive by asking clients to make contact with aspects of their experience.

Humanistic therapists refrain from presenting themselves as authority figures, and maintain the belief that they are unable to know more about clients' lives than they do, allowing them to be present with clients, rather than focusing on what they are doing to solve clients' problems.

APPENDIX B: LGB AFFIRMATIVE THERAPY DESCRIPTION

Lesbian, Gay, and Bisexual (LGB) Affirmative Therapy

Theory of Psychological Problems:

LGB affirmative therapy, also called gay affirmative therapy (LGB-AT), recognizes that lesbian, gay, and bisexual clients experience the same problems that heterosexual clients experience, but that they often present with additional treatment issues specific to LGB individuals. These include, but are not limited to, concerns about stigma, heterosexism (prejudice and discrimination against sexual minorities), the coming-out process, interactions with the family of origin, and how sexual orientation may interact with any other minority identities (e.g. race). According to this treatment approach, discriminatory societal messages about sexual minorities can negatively affect LGB individuals' self-esteem. This may occur, in part, because LGB individuals often feel they need to hide their sexual orientation or shape their behavior to reduce stigma and prejudice. LGB-AT examines how these issues can affect mental health and lead to psychological distress. Models of LGB affirmative therapy emerged in the 1980s and have been modified over time to inform practice with LGB clients.

Aims and goals:

Goals of LGB-AT are to affirm the client's identity as a member of the LGB community and to reduce his or her psychological distress and negative self-attitudes, particularly when these result from heterosexist societal values. The affirmative focus of LGB-AT promotes the clients' self-acceptance and allows healing to occur. This, in turn, achieves

the primary goal: clients are better able to live their lives in ways that are congruent with their talents, skills and dreams.

Method and contract:

LGB-AT is not typically a stand-alone intervention and thus does not have a standard length nor is it bound by a specific number of sessions. The methods used in LGB-AT are often tailored to a specific stage in clients' identity development or coming-out process. Tasks are focused on providing LGB individuals with coping skills for minimizing distress created by a largely heterosexist society. This involves reversing any internalized neLGB-ATive stereotypes of LGB individuals as well as any existing shame and guilt related to same-sex thoughts or feelings. The process also includes the exploration of emotions such as anxiety, depression, or anger, which are common responses to stigma. Recognizing that these kinds of emotions are normal responses to oppression is often freeing for clients, releasing the neLGB-ATive "hold" the emotions have on the mind.

The LGB-AT therapist also focuses on fostering an LGB support system and the client's involvement in activities of the sexual minority community. LGB-AT provides education and resources about LGB family issues, development of relationships, and safety issues regarding transmission of STIs.

Role relationship between client and therapist:

Before entering therapy with a LGB client, the therapist must examine his or her own attitudes towards homosexuality and sexual minorities and come to an understanding about how heterosexism impacts LGB individuals' experiences. Furthermore, the therapist may initiate discussions of how the therapist's and client's views about sexual

orientation may impact the therapy relationship. For heterosexual therapists in particular, this could include discussions about instances of subtle prejudice that may inadvertently occur during session. In therapy, the therapist fosters a supportive relationship with the client, one that embodies the acceptance and understanding that the client may not receive from other peer relationships. Simultaneously, the therapist uses his or her expertise to validate and affirm the client's thoughts and feelings related to being LGB.



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